Health Care

Medicare and Medicaid are the nation's major health and medical insurance programs. Medicare is a federal program for aged and disabled persons who are insured under the Social Security program. Medicaid covers eligible persons with limited income and resources. The Medicaid program is funded jointly by the federal government and the states and is state-administered.

Medicare

Title XVIII of the Social Security Act, entitled "Health Insurance for the Aged and Disabled," became law on July 30, 1965, and is commonly known as Medicare. As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act.

When first implemented in 1966, Medicare covered most persons aged 65 or older. The Social Security Amendments of 1972 extended protection to disabled persons, entitled because of their disability to monthly cash benefits under the Social Security or Railroad Retirement programs and to certain individuals with end-stage renal (kidney) disease. Effective July 1, 1973, Title XVIII thus became Health Insurance for the Aged and Disabled.

Medicare consists of two primary parts, which are separate but coordinated fee-for-service programs: Hospital Insurance (HI), also known as Part A, and Supplementary Medical Insurance (SMI), also known as Part B Both parts are explained in more detail later. Basically, Part A helps pay for inpatient hospital care, skilled-nursing facility, home health, and hospice care, while Part B helps pay for physician, outpatient, and home health care, and various other medical services. A third part of Medicare, sometimes known as Part C, is the Medicare+Choice program. Medicare+Choice was established by the Balanced Budget Act of 1997 and began providing services on January 1, 1998. All Medicare beneficiaries can receive their Medicare benefits through the original fee-for-service programs. In addition, most beneficiaries can choose instead to receive their Medicare benefits through a Medicare+Choice plan, which is described in more detail later. Basically, the plan expands options for the delivery of health care under Medicare.

Hospital Insurance

Individuals who are eligible for Social Security or Railroad Retirement benefits are eligible for premium-free Hospital Insurance (HI) benefits when they reach age 65, whether they have claimed monthly benefits or not. Also, workers and their spouses with a sufficient period of Medicare-only coverage in federal, state, or local government employment are eligible at age 65.

In addition, HI protection is provided to disabled beneficiaries (but not their dependents) who have been entitled to Social Security or Railroad Retirement disability benefits for at least 24 months (or government employees with Medicare-only coverage who have been disabled for more than 29 months), and to insured workers (and their spouses and children) with end-stage renal disease who require renal dialysis or a kidney transplant. The Social Security Amendments of 1980 (P.L. 96-265) eliminated the requirement that the 24 months be consecutive, effective December 1, 1980, and provided that months from previous periods of disability benefit entitlement may be counted in determining whether the monthly qualifying period requirement is met, subject to certain time limits. The Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203) eliminated the time limits.

Also eligible for HI enrollment, under transitional provisions created

at the program's onset, are persons aged 65 or older with specified amounts of earnings credits less than those required for monthly benefit eligibility. (Not eligible under the transitional provisions are retired federal employees covered by the Federal Employees' Health Benefits Act of 1959 or aliens admitted for permanent residence unless they have 5 consecutive years of residence and the required covered quarters under these provisions.)

The Tax Equity and Fiscal Responsibility Act of 1982 required that federal employees be covered for HI protection, effective January 1983. Federal workers employed during January 1983 were permitted upon retirement to use federal wage quarters before 1983 to establish entitlement to HI benefits, if needed.

Since July 1973, most persons aged 65 or older and otherwise ineligible for HI have been permitted to enroll voluntarily and pay a monthly premium for HI protection if they are enrolled for SMI. If they have 30 or more quarters of coverage under the Social Security program, the 1998 cost of HI is the reduced amount of $170 per month; if not, the cost is $309 per month. OBRA 1989 extended the option of voluntary coverage upon payment of the HI premium to disabled individuals for whom monthly cash benefits have ceased due to substantial gainful activity.

Benefits provided.—Under the HI program, beneficiaries may receive the following four kinds of medically necessary care: (1) inpatient hospital care; (2) inpatient care in a skilled-nursing facility (SNF) following a hospital stay; (3) home health care; and (4) hospice care.

- *Inpatient hospital care*. Covered hospital care includes all those services ordinarily furnished by a hospital to its patients, such as semiprivate accommodations, meals, operating and recovery rooms, laboratory procedures and X-rays, drugs and biologicals, nursing services (excluding payments for private-duty nursing), therapy services, and services of interns and residents in training. Benefits include reimbursement for inpatient tuberculosis and psychiatric hospital services—with a lifetime limit of 190 days of care in a psychiatric hospital—and emergency inpatient care in a nonparticipating hospital. Psychiatric care in general hospitals, rather than in free-standing psychiatric hospitals, is not subject to the 190-day limit and is treated the same as other Medicare inpatient hospital care.

  Effective January 1, 1998, once a Medicare beneficiary has paid the inpatient hospital deductible ($768 in 1999), all remaining costs of covered hospital services for the first 60 days in a benefit period will be paid by Medicare (see table 2.C1). A benefit period starts when a beneficiary first enters a hospital and ends when there has been a break of at least 60 consecutive days since inpatient skilled nursing care was provided. From the 61st through the 90th day in a benefit period, the patient pays a daily coinsurance amount equal to one-fourth the inpatient hospital deductible ($192 in 1999).

  Each HI beneficiary also has a lifetime reserve of 60 additional hospital days that may be used when the covered days within a benefit period have been exhausted. Lifetime reserve days may be used only once and the daily coinsurance amount is one-half the inpatient hospital deductible ($384 in 1999).
- *Skilled nursing facility care*. Following hospitalization of at least 3 consecutive days, if a patient requires subsequent skilled nursing care or skilled rehabilitation services on a daily basis, but not hospital care, such services are covered in an institution or section of a hospital that qualifies as a skilled-nursing facility. Payment for up to 100 days of care per benefit period is covered with no coinsurance for the first 20 days, and daily coinsurance for days 21 through 100. This daily coinsurance rate is one-eighth of the inpatient hospital deductible ($96 per day in 1999).
- *Home health care (part-time or intermittent skilled-nursing care, physical therapy, or speech therapy provided in the residence of a home-bound beneficiary).* As a result of the Balanced Budget Act of 1997 (P.L. 105-33), for individuals enrolled in both the HI and SMI programs, the first 100 visits of post-institutional home health services (that is, home health services associated with a hospital stay of at least 3 consecutive days or with a skilled-nursing facility stay) are covered by the HI program, while home health services not of a post-institutional nature, and post-institutional visits beyond the first 100 are covered by the SMI program.

  For individuals enrolled in only the HI program or only the SMI program, the program in which they are enrolled pays for the entire range of home health care services (that is, the first 100 post-institutional visits, post-institutional visits beyond the first 100, and nonpost-institutional visits). These provisions of the Balanced Budget Act became effective January 1, 1998. Within this framework, home visits are covered if the beneficiary is homebound (but need not be bedridden), and if a physician sets up a home health plan after determining that the individual requires skilled-nursing care on an intermittent basis or is in need of physical or speech therapy.

Other services can include necessary part-time or intermittent home health aide services, occupational therapy, medical social services, and medical supplies. Medicare pays the reasonable cost of all covered home health visits. Durable medical equipment furnished as part of the home health plan is subject to a 20 percent coinsurance (that is, the beneficiary must pay 20 percent of the cost). Home health care has no co-payment and no deductible. However, full-time nursing care, food, blood, and drugs are not provided as home health agency services.

- *Hospice care*. Added in 1983, services are provided to beneficiaries certified as terminally ill; these services cover two 90-day hospice benefit periods, followed by an unlimited number of 60-day periods. When these services—often provided in the beneficiary's home—are furnished by a Medicare-certified facility, the coverage includes: physician services, nursing care, medical appliances and supplies, drugs for symptom management and pain relief, short-term inpatient care, counseling, therapies, home health aide, and homemaker services.

  Part A and B deductibles do not apply to services and supplies furnished under the hospice benefit, and the beneficiary pays only limited charges for outpatient drugs and inpatient respite care. The beneficiary pays deductibles and coinsurance amounts when regular Medicare benefits are used for treatment of a condition other than the terminal illness. For the hospice program, there is a "cap" on per person expenditures.

HI financing and administration.—Hospital Insurance is financed by a tax on earnings that is separate from the tax used to finance Old-Age, Survivors, and Disability Insurance (OASDI) benefits. Before January 1991, the OASDI and HI taxes were applied to the same maximum earnings base ($51,300 in 1990). However, beginning in 1991 (under P.L. 101-508), annual earnings up to $125,000 were subject to HI taxes, with the amount indexed to increases in average wages in the economy after 1991. The maximum earnings base for HI was $130,200 in 1992 and $135,000 in 1993.

The Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) repealed the dollar limit on wages and self-employment income subject to HI taxes, effective January 1,1994. The HI contribution rate of 1.45 percent applies equally to employers and employees. The rate for the self-employed equals the combined employer and employee rate of 2.9 percent.[1] The income is channeled into a separate Federal Hospital Insurance Trust Fund (see table 2.A3), established on a basis similar to that of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds. All Hospital Insurance benefits and administrative costs are paid from this trust fund. The HI Trust Fund is reimbursed from general revenues for the cost of providing HI coverage under the transitional provisions for certain aged persons not entitled to OASDI or Railroad Retirement benefits, and receives other miscellaneous income as well (see table 8.A1).

The Secretary of Health and Human Services has overall responsibility for administering the HI program. In 1965, a new component was created in the Social Security Administration (SSA) to manage the Medicare program. In March 1977, management was transferred from SSA to the newly formed Health Care Financing Administration (HCFA). Responsibility for administering the federal Medicare program and the combined federal-state Medicaid programs rests with HCFA. SSA is responsible for the initial determination of an individual's entitlement and has overall responsibility for maintaining Medicare data on the master beneficiary record, the Social Security Administration's primary record of beneficiaries.

As provided by law, the administrators of the HI program have entered into agreements with state agencies and private organizations to secure their assistance in administering the program. HCFA develops regulations and guidelines to determine if hospitals, skilled-nursing facilities, and other providers of medical services meet the conditions for program participation. These standards include the requirements for medical and nursing staff, the physical environment in which care is provided, the maintenance of records, and the overall quality of care being provided. State agencies—usually health departments—apply the standards and also render consultative services to health care providers. Each participating provider must agree to limit beneficiary service charges to the applicable deductibles and coinsurance.

Hospitals and skilled-nursing facilities nominate a fiscal intermediary to process claims for HI benefits and to make payment settlements. The intermediaries are assigned by HCFA on a regional basis. Both Blue Cross/Blue Shield plans and commercial insurance companies serve as intermediaries whose responsibilities include:

- determining costs and reimbursement amounts;
- maintaining records;
- establishing controls;
- safeguarding against fraud and abuse or excess use;
- conducting reviews and audits;

[1] Beginning in 1990, the law allowed (1) a reduction in net self-employment earnings to which the OASDI and HI tax applies and (2) an income tax deduction of one-half the OASDI and HI taxes paid.

- making the payments to providers for services; and
- assisting both providers and beneficiaries as needed.

Skilled nursing facilities, home health agencies, and some hospitals are reimbursed on the basis of reasonable costs, subject to certain monetary limits. Most hospitals are paid under a prospective payment system with rates set in advance and related to the patient's diagnosis. Hospices are paid prospectively set rates based on the level of care.

Ordinarily, payments are made only for services provided in the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

To improve the quality and effectiveness of Medicare services, the 1972 amendments authorized the establishment of medical review groups, called Professional Standards Review Organizations (PSROs). The 1982 amendments replaced the PSROs with Peer Review Organizations (PROs). A PRO (one in each state) is composed of local practicing physicians organized for the purpose of conducting peer reviews. The PROs are responsible for assuring that the care provided to Medicare beneficiaries is medically necessary and reasonable, provided in the appropriate setting (hospital versus nonhospital), reviewing the validity of hospitals' diagnostic information, reviewing the appropriateness of admissions and discharges, deciding if professionally accepted standards of quality are being met, and reviewing the appropriateness of care for which additional payment is sought for extraordinarily costly cases. To receive Medicare payments, each hospital must have an agreement with a PRO. In addition, measures to further prevent Medicare fraud and abuse were enacted in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and strengthened in the Balanced Budget Act of 1997 (P.L. 105-33).

Supplementary Medical Insurance

All individuals aged 65 or older who are citizens, or aliens lawfully admitted for permanent residence with 5 consecutive years of residence, and all disabled persons entitled to coverage under HI are eligible to enroll in the SMI program on a voluntary basis by payment of a monthly premium.

From 1984 through 1990, the Part B premium was set to cover 25 percent of program costs for aged beneficiaries, with the remaining 75 percent covered by general revenues of the federal government. OBRA 1990 established the monthly Part B premium in statute through 1995 as follows: $29.90 in 1991, $31.80 in 1992, $36.60 in 1993, $41.10 in 1994, and $46.10 in 1995. OBRA 1993 again established the provision requiring that Part B premiums cover 25 percent of program costs in 1996, 1997, and 1998. The Balanced Budget Act of 1997 permanently set the Part B premium at 25 percent of program costs.

In 1999, enrolled individuals pay a monthly premium of $45.50 that is deducted from their Social Security benefit, Railroad Retirement annuity, or federal Civil Service Retirement annuity (the 1998 premium was $43.80). Enrollees not receiving their benefits are billed quarterly. SMI costs not covered by premiums are financed from general revenues of the federal government (a total of 73 percent of SMI income in 1998). Individuals may either pay the premium or be eligible to have the state social service or medical assistance agency pay the premium on their behalf.

Persons may terminate their enrollment in the SMI program at any time by filing a notice with SSA. If persons withdraw before coverage starts, there is no premium liability. However, the premium rate is increased by 10 percent for each full year out of the program for persons who do not enroll as soon as they are eligible. (Special waivers of the premium surcharge are available to employees or spouses who continue coverage under an employer health insurance plan.) Enrollment may also be terminated for failure to pay the premium.

Benefits provided.—The SMI program covers the following services and supplies, which must be medically necessary to be covered:

- Physicians' and surgeons' services, including some covered services furnished by chiropractors, podiatrists, dentists, and optometrists (except routine physical examinations and routine care of the eyes, ears, and feet, and most immunizations and cosmetic surgery). Also covered are the following Medicare-approved practitioners who are not physicians:
- Certified registered nurse anesthetists.
- Clinical psychologists.
- Clinical social workers (other than in a hospital or skilled-nursing facility).
- Physician assistants.
- Nurse practitioners and clinical nurse specialists in collaboration with a physician.
- Services in an emergency room or outpatient clinic, including same-day surgery.
- Home health care, as described in the Hospital Insurance section.
- Laboratory tests, X-rays, and other radiology services billed by the hospital, as well as approved independent laboratory services, portable diagnostic X-ray services, pap smear screening, mammography, prostate cancer screening, colorectal screening, and bone mass detection.
- Mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it.

- Ambulatory surgical center services in Medicare-approved facility.
- Physical and occupational therapy, and speech pathology services under a plan established by a physician on an outpatient basis in a participating hospital, skilled-nursing facility, participating home health agency, rehabilitation agency, or public health agency.
- Comprehensive outpatient rehabilitation facility services, nonhospital treatment of a mental illness, and partial hospitalization for mental health treatment.
- Radiation therapy, renal (kidney) dialysis and transplants, and heart and liver transplants under certain limited conditions.
- Approved durable medical equipment for home use, such as oxygen equipment and wheelchairs; prosthetic devices; and surgical dressings, splints, and casts.
- Drugs and biologicals that cannot be self-administered (certain self-administered anticancer drugs are covered), such as pneumococcal pneumonia vaccine, hepatitis B vaccine, hemophilia clotting factors, transfusions of blood and blood components not supplied under Part A, antigens, immunosuppresive drugs, epogen when used to treat anemia related to chronic kidney failure or to HIV-positive beneficiaries, and flu vaccinations.

For Part B, cost-sharing contributions are required of beneficiaries which include: one annual deductible (now $100); the monthly premiums; coinsurance payments for Part B services (usually 20 percent of charges); a blood deductible; charges above the Medicare allowed charge (for claims not on assignment); and payment for any services that are not covered by Medicare. For outpatient mental health treatment services, the beneficiary is liable for 50 percent of the approved charges.

Payments for most SMI covered services are made on either a cost or a charge basis. If payments are on a cost basis (to some providers of services), the intermediary must ascertain the reasonable cost. If the payments are on a charge basis (to physicians or others furnishing individual services), the carrier must verify that such charges meet the existing reasonable charge guidelines. Outpatient clinical laboratory services are reimbursed on the basis of fee schedules, and limitations are placed on certain other services.

Noncovered services under Medicare include long-term nursing care or custodial care, and certain other health care needs such as eyeglasses, hearing aids, prescription drugs (except certain self-administered anticancer drugs), dentures and dental care, and so forth. These are not a part of either the HI or the SMI program, unless they are a part of a managed care plan (prepaid health care plan), such as a health maintenance organization (HMO), which is an option for Medicare beneficiaries.

Physicians must submit the claims for all physician services regardless whether assignment is accepted. The physician then bills the beneficiary for any remaining deductible and 20 percent of the balance of the allowed charge. In addition, in cases where the physician did not accept assignment, the physician may charge the beneficiary no more than 15 percent of the allowed charge. Alternately, for other services reimbursed on an allowed charge basis, the supplier may submit the bill for the beneficiary without accepting assignment, and the patient remains responsible for the total bill and is paid by Medicare. Should the supplier accept assignment, the supplier must submit the claim directly for payment, agreeing to accept the carrier's determination for allowed charges as the full fee for the services involved. Under these circumstances, the patient then pays no more than the remaining deductible and 20 percent of the balance of the allowed charge.

Physicians and suppliers may also voluntarily "participate" in Medicare and always accept assignment instead of making the decision each time a service is provided. A beneficiary who used a participating physician or supplier is assured that he or she will not be responsible for more than the initial deductible and the coinsurance applicable to the reasonable charge.

Before 1992, the Medicare reasonable charge, known as the reasonable charge, was the lowest of (1) the customary charge (generally the charge most frequently made) by each physician and supplier for each separate service or supply furnished to patients in a previous 12-month period, (2) the prevailing charge (the amount that is high enough to cover the customary charges in 3 out of 4 bills submitted in the previous year for each service and supply) for each covered service and supply, or (3) the actual charge.

Increases in prevailing charges for physicians' services were ordinarily limited from year to year by an economic index formula that relates physicians' fee increases to the actual increases in the cost of maintaining a practice and to rises in general earnings levels. OBRA 1989 (P.L. 101-239) provided for the replacement of customary and prevailing charges, with new fee schedules for physicians' services starting in 1992, based on a relative value scale. The fee schedule amount was equal to the product of the procedure's relative value, a conversion factor, and a geographic adjustment factor. Payments were based on the lower of the actual charge and the fee schedule amount. For the 4-year period from 1992 to 1995, the fee schedule amounts were to be adjusted to reflect the prevailing charges in each fee screen area.

Under OBRA 1993 (P.L. 103-66), the physician fee schedule update reflects changes in the Medicare Economic Index, performance

adjustment and legislation. In 1994, the Part B fee schedule update for physician services was reduced by 3.6 percent for surgical services, and 2.6 percent for all other services (including anesthesia services), with the exception of primary care services which will receive the full update. For 1995, the update was reduced by 2.7 percent for surgical and all other services, with the exception of primary care services, which received the full update. The 1993 law also included cost restraint provisions applicable to skilled-nursing facilities, hospices, laboratory services, anesthesia care teams, other services, and expense computations.

SMI financing and administration.— The SMI program is financed through the Federal Supplementary Medical Insurance Trust Fund, into which are placed the premiums paid by enrollees ($45.50 per month in 1999, usually deducted from monthly Social Security benefit checks), and the amount paid by the federal government from general revenues. The trust fund receives other miscellaneous income as well (see table 8.A2). Responsibility for administration of the SMI program, like the HI program, was transferred from SSA to HCFA in March 1977.

As provided by law, HCFA enters into contracts with carriers to serve as administrative agents for claims processing. The federal government reimburses the carrier for administrative expenses. Blue Cross/Blue Shield plans and commercial insurance companies operate as carriers to process SMI claims for services furnished by physicians and other health care providers. Carriers perform specific functions such as determining allowable payments; holding, disbursing, and accounting for funds; assisting in the application of safeguards against unnecessary utilization of services; granting hearings to individuals with contested claims; maintaining quality of performance records; assisting in fraud and abuse investigations; and assisting both suppliers and beneficiaries as needed. Some institutional providers of services, such as home health agencies, hospital outpatient departments, and comprehensive outpatient rehabilitation centers, are served by HI intermediaries.

Medicare+Choice

An expanded set of options for the delivery of health care under Medicare, referred to as Medicare+Choice, was established by the Balanced Budget Act of 1997 (P.L. 105-33). All Medicare beneficiaries can receive their Medicare benefits through the original fee-for-service program. In addition, most beneficiaries enrolled in both Parts A and B can choose instead to receive their Medicare benefits through one of the following Medicare+Choice plans:

- Coordinated care plans (such as health maintenance organizations, provider-sponsor organizations, and preferred provider organizations);
- Medical Savings Account (MSA)/High Deductible plans (through a demonstration available up to 390,000 beneficiaries); or
- Private fee-for service plans.

Except for MSA plans, all Medicare+Choice plans are required to provide the current benefit package provided under Medicare Parts A and B (excluding hospice services) and any additional health services required under the adjusted community rate (ACR) process. MSA plans provide Medicare benefits after a single high deductible is met, and enrollees receive an annual deposit in their Medical Savings Account.

Transition rules for the prior Medicare managed care program were also provided by the Balanced Budget Act.

Recent Legislation and Program Changes

The Balanced Budget Act of 1997 (P.L. 105-33), enacted on August 5, 1997, included a number of provisions affecting the Medicare program. The new Medicare+Choice options and the changes regarding home health care coverage under the two parts of Medicare, both previously addressed, were two of the major provisions included in the Balanced Budget Act. These and the other major provisions of the Balanced Budget Act are described in the following section entitled Medicare: History of Provisions. All entries for 1997 in the Medicare: History of Provisions section are provisions that were contained in the Balanced Budget Act.